Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

# General

## Guideline Title

VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder.

## Bibliographic Source(s)

Management of Posttraumatic Stress Disorder Work Group. VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Jun. 200 p. [259 references]

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of Post-Traumatic Stress Working Group. VA/DoD clinical practice guideline for management of post-traumatic stress. Washington (DC): Veterans Health Administration, Department of Defense; 2010. 251 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

# NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

| Assessment | Standard of Trustworthiness |
|---|---|
| YES | Disclosure of Guideline Funding Source |
| | Disclosure and Management of Financial Conflict of Interests |
| | |

| | |
|---|---|
| | Guideline Development Group Composition |
| YES | Multidisciplinary Group |
| YES | Methodologist Involvement |
| ▮▮▮▮▮ | Patient and Public Perspectives |
| | Use of a Systematic Review of Evidence |
| ▮▮▮▮▮ | Search Strategy |
| ▮▮▮▮▮ | Study Selection |
| ▮▮▮▮▮ | Synthesis of Evidence |
| | Evidence Foundations for and Rating Strength of Recommendations |
| ▮▮▮▮▯ | Grading the Quality or Strength of Evidence |
| ▮▮▮▮▮ | Benefits and Harms of Recommendations |
| ▮▮▮▮▮ | Evidence Summary Supporting Recommendations |
| ▮▮▮▮▮ | Rating the Strength of Recommendations |
| ▮▮▮▮▮ | Specific and Unambiguous Articulation of Recommendations |
| ▮▮▮▮▮ | External Review |
| ▮▮▮▮▮ | Updating |

# Recommendations

## Major Recommendations

*Note from the Department of Veterans Affairs and the Department of Defense (VA/DoD) and the National Guideline Clearinghouse (NGC)*: The recommendations for the management of posttraumatic stress disorder are organized into 5 sections (A-E below) and 3 modules with 3 algorithms. The accompanying recommendations are provided below. See the original guideline document for the algorithms and evidence tables associated with selected recommendations, including level and quality of evidence, strength of recommendation, and supporting evidence citations.

The strength of recommendation grading (Strong For, Weak For, Strong Against, Weak Against) and recommendation categories (Reviewed, Not reviewed, New-added, New-replaced, Not changed, Amended, Deleted) are defined at the end of the "Major Recommendations" field.

A. General Clinical Management

The Work Group recommends engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options. (Strong For; Not Reviewed, Amended)
For patients with posttraumatic stress disorder (PTSD) who are treated in primary care, the Work Group suggests collaborative care interventions that facilitate active engagement in evidence-based

treatments. (Weak For; Reviewed, New-replaced)

B. Diagnosis and Assessment of PTSD

The Work Group suggests periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL). (Weak For; Not Reviewed, Amended)

For patients with suspected PTSD, the Work Group recommends an appropriate diagnostic evaluation that includes determination of Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, acute risk of harm to self or others, functional status, medical history, past treatment history, and relevant family history. A structured diagnostic interview may be considered. (Strong For; Not Reviewed, Amended)

For patients with a diagnosis of PTSD, the Work Group suggests using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist for DSM, fifth edition (DSM-5) (PCL-5), in the initial treatment planning and to monitor treatment progress. (Weak For; Not Reviewed, Amended)

C. Prevention of PTSD

Selective Prevention of PTSD

For the selective prevention of PTSD, there is insufficient evidence to recommend the use of trauma-focused psychotherapy or pharmacotherapy in the immediate post-trauma period. (N/A; Reviewed, New-replaced)

Indicated Prevention of PTSD and Treatment of Acute Stress Disorder (ASD)

For the indicated prevention of PTSD in patients with ASD, the Work Group recommends an individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring. (Strong For; Reviewed, New-replaced)

For the indicated prevention of PTSD in patients with ASD, there is insufficient evidence to recommend the use of pharmacotherapy. (N/A; Reviewed, New-replaced)

D. Treatment of PTSD

Treatment Selection

The Work Group recommends individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD. (Strong For; Reviewed, New-added)

When individual trauma-focused psychotherapy is not readily available or not preferred, the Work Group recommends pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other. (Strong For; Reviewed, New-added)

Psychotherapy

For patients with PTSD, the Work Group recommends individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. (Strong For; Reviewed, New-replaced)

The Work Group suggests the following individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD: Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT). (Weak For; Reviewed, New-replaced)

There is insufficient evidence to recommend for or against psychotherapies that are not specified in other recommendations, such as Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety, and

supportive counseling. (N/A; Reviewed, New-replaced)
There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol. (N/A; Reviewed, New-added)
The Work Group suggests manualized group therapy over no treatment. There is insufficient evidence to recommend using one type of group therapy over any other. (Weak For; Reviewed, New-replaced)
There is insufficient evidence to recommend for or against trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD. (N/A; Reviewed, Amended)

Pharmacotherapy

The Work Group recommends sertraline, paroxetine, fluoxetine, or venlafaxine as monotherapy for PTSD for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy. (Strong For; Reviewed, New-replaced)
The Work Group suggests nefazodone, imipramine, or phenelzine as monotherapy for the treatment of PTSD if recommended pharmacotherapy (see Recommendation 17), trauma-focused psychotherapy (see Recommendation 11), or non-trauma-focused psychotherapy (see Recommendation 12) are ineffective, unavailable, or not in accordance with patient preference and tolerance. (NOTE: Nefazodone and phenelzine have potentially serious toxicities and should be managed carefully.) (Weak For; Reviewed, New-replaced)
The Work Group suggests against treatment of PTSD with quetiapine, olanzapine, and other atypical antipsychotics (except for risperidone, which is a Strong Against, see Recommendation 20), citalopram, amitriptyline, lamotrigine, or topiramate as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks. (Weak Against; Reviewed, New-replaced)
The Work Group recommends against treating PTSD with divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone, or D-cycloserine as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks. (Strong Against; Reviewed, New-replaced)
The Work Group recommends against treating PTSD with cannabis or cannabis derivatives due to the lack of evidence for their efficacy, known adverse effects, and associated risks. (Strong Against; Reviewed, New-added)
There is insufficient evidence to recommend for or against monotherapy or augmentation therapy for the treatment of PTSD with eszopiclone, escitalopram, bupropion, desipramine, doxepin, D-serine, duloxetine, desvenlafaxine, fluvoxamine, levomilnacipran, mirtazapine, nortriptyline, trazodone, vilazodone, vortioxetine, buspirone, hydroxyzine, cyproheptadine, zaleplon, and zolpidem. (N/A; Reviewed, New-replaced)

Augmentation Therapy

The Work Group suggests against the use of topiramate, baclofen, or pregabalin as augmentation treatment of PTSD due to insufficient data and/or known adverse effect profiles and associated risks. (Weak Against; Reviewed, New-replaced)
The Work Group suggests against combining exposure therapy with D-cycloserine in the treatment of PTSD outside of the research setting. (Weak Against; Reviewed, New-added)
The Work Group recommends against using atypical antipsychotics, benzodiazepines, and divalproex as augmentation therapy for the treatment of PTSD due to low quality evidence or the absence of studies and their association with known adverse effects. (Strong Against; Reviewed, New-replaced)
There is insufficient evidence to recommend the combination of exposure therapy with hydrocortisone outside of the research setting. (N/A; Reviewed, New-added)
There is insufficient evidence to recommend for or against the use of mirtazapine in combination with sertraline for the treatment of PTSD. (N/A; Reviewed, New-replaced)

Prazosin

For global symptoms of PTSD, the Work Group suggests against the use of prazosin as mono- or augmentation therapy. (Weak Against; Reviewed, New-replaced)

For nightmares associated with PTSD, there is insufficient evidence to recommend for or against the use of prazosin as mono- or augmentation therapy. (N/A; Reviewed, New-replaced)

Combination Therapy

In partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy. (N/A; Reviewed, New-replaced)
In partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy. (N/A; Reviewed, New-replaced)
There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy. (N/A; Reviewed, New-added)

Non-pharmacologic Biological Treatments

There is insufficient evidence to recommend for or against the following somatic therapies: repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB), or vagal nerve stimulation (VNS). (N/A; Reviewed, New-replaced)

Complementary and Integrative Treatments

There is insufficient evidence to recommend acupuncture as a primary treatment for PTSD. (N/A; Reviewed, New-replaced)
There is insufficient evidence to recommend any complementary and integrative health (CIH) practice, such as meditation (including mindfulness), yoga, and mantram meditation, as a primary treatment for PTSD. (N/A; Reviewed, New-replaced)

Technology-based Treatment Modalities

The Work Group suggests internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment. (Weak For; Reviewed, New-replaced)
The Work Group recommends using trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality when PTSD treatment is delivered via VTC. (Strong For; Reviewed, Amended)

E. Treatment of PTSD with Co-occurring Conditions

The Work Group recommends that the presence of co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD. (Strong For; Reviewed, New-added)
The Work Group recommends VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD). (Strong For; Reviewed, New-replaced)
The Work Group recommends an independent assessment of co-occurring sleep disturbances in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment. (Strong For; Reviewed, New-replaced)
The Work Group recommends Cognitive Behavioral Therapy for Insomnia (CBT-I) for insomnia in patients with PTSD unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medication to prevent harm. (Strong For; Reviewed, Amended)

Definitions

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive

measure indicates that the undesirable consequences outweigh the desirable consequences.

Occasionally, instances may occur when the Work Group feels there is insufficient evidence to make a recommendation for or against a particular therapy or preventive measure. This can occur when there is an absence of studies on a particular topic that met evidence review inclusion criteria, studies included in the evidence review report conflicting results, or studies included in the evidence review report inconclusive results regarding the desirable and undesirable outcomes.

Using these elements, the grade of each recommendation is presented as part of a continuum:

Strong For (or "The Work Group recommends offering this option …")
Weak For (or "The Work Group suggests offering this option …")
Weak Against (or "The Work Group suggests not offering this option …")
Strong Against (or "The Work Group recommends against offering this option …")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

Recommendation Categories and Definitions

For use in the 2017 PTSD clinical practice guideline (CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated.

| Evidence Reviewed* | Recommendation Category* | Definition* |
|---|---|---|
| Reviewed | New-added | New recommendation following review of the evidence |
| | New-replaced | Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence |
| | Not changed | Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed |
| | Amended | Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made |
| | Deleted | Recommendation from the previous CPG that has been removed based on review of the evidence |
| Not reviewed | Not changed | Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed |
| | Amended | Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made |
| | Deleted | Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG |

*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

## Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

Module A: Acute Stress Reaction/Disorder
Module B: Assessment and Diagnosis of Posttraumatic Stress Disorder
Module C: Management of Posttraumatic Stress Disorder

# Scope

## Disease/Condition(s)

- Posttraumatic stress disorder (PTSD)
- Acute stress disorder

## Guideline Category

Counseling

Diagnosis

Evaluation

Management

Prevention

Treatment

## Clinical Specialty

Family Practice

Psychiatry

Psychology

## Intended Users

Advanced Practice Nurses

Health Care Providers

Health Plans

Hospitals

Managed Care Organizations

Nurses

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

## Guideline Objective(s)

To assist providers in managing or co-managing patients with posttraumatic stress disorder (PTSD) and related conditions (e.g., acute stress disorder [ASD])

## Target Population

Adults 18 years or older with posttraumatic stress disorder (PTSD) or acute stress disorder (ASD) treated in any Department of Veterans Affairs (VA)/Department of Defense (DoD) clinical setting

Note: This clinical practice guideline (CPG) does not provide recommendations for the management of posttraumatic stress disorder (PTSD) in children or adolescents.

## Interventions and Practices Considered

1. General clinical management
    - Use of patient-centered care and shared decision making
    - Collaborative care interventions
    - Diagnosis and assessment of posttraumatic stress disorder (PTSD)
        - Periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL)
        - Diagnostic evaluation
            - Determination of Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria
            - Determination of acute risk of harm to self or others
            - Functional status
            - Patient history (medical history, past treatment history, and relevant family history)
        - Using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist for DSM, fifth edition (DSM-5) (PCL-5), in the initial treatment planning and to monitor treatment progress
2. Prevention
    - Selective prevention of PTSD (insufficient evidence for recommendations on use of psychotherapy or pharmacotherapy)
    - Indicated prevention of PTSD and treatment of acute stress disorder (ASD)
        - Individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring
        - Pharmacotherapy (insufficient evidence for recommendation)
3. Treatment
    - Treatment selection (trauma-focused versus non-trauma-focused psychotherapy versus pharmacotherapy)
    - Psychotherapy†
        - Prolonged Exposure (PE)
        - Cognitive Processing Therapy (CPT)
        - Eye Movement Desensitization and Reprocessing (EMDR)
        - Specific cognitive behavioral therapies for PTSD
        - Brief Eclectic Psychotherapy (BEP)
        - Narrative Exposure Therapy (NET)
        - Written narrative exposure
        - Stress Inoculation Training (SIT)
        - Present-Centered Therapy (PCT)
        - Interpersonal Psychotherapy (IPT)

        - Group therapy
    - Pharmacotherapy (monotherapy)*†
        - Sertraline
        - Paroxetine
        - Fluoxetine
        - Venlafaxine
        - Nefazodone
        - Imipramine
        - Phenelzine
4. Augmentation therapy†
5. Prazosin (recommendation against use for global PTSD symptoms; insufficient evidence to make recommendation for treatment of nightmares)
6. Combination therapy†
7. Non-pharmacologic biological treatments†
8. Complementary and integrative treatments†
9. Technology-based treatment modalities
    - Internet-based cognitive behavioral therapy (iCBT)
    - Video teleconferencing (VTC)
10. Treatment of PTSD with Co-occurring Conditions
    - Treatment for PTSD in the presence of co-occurring disorders including substance use disorders
    - Independent assessment of co-occurring sleep disturbances
    - Cognitive Behavioral Therapy for Insomnia (CBT-I)

*Note: Quetiapine, olanzapine, and other atypical antipsychotics, citalopram, amitriptyline, lamotrigine, and topiramate were not recommended as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks. Divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone, and D-cycloserine as monotherapy were strongly recommended against use due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks. Cannabis or cannabis derivatives were also recommended against due to the lack of evidence for their efficacy, known adverse effects, and associated risks.

†Note: A number of other pharmacologic and nonpharmacologic or complementary therapies were considered either as monotherapy or augmentation therapy but no recommendation was made because of insufficient evidence. See the "Major Recommendations" field for specific information.

## Major Outcomes Considered

Primary outcomes:

Improvement in global posttraumatic stress disorder (PTSD) severity based on clinician-administered PTSD scale (CAPS) or other validated structured clinical interviews
Adverse events
Retention/dropout rate
Loss of diagnosis/remission

Secondary outcomes:

Self-reported PTSD
Specific symptom improvement (e.g., sleep, anger/aggression)
Comorbid symptoms (e.g., depression, anxiety, substance-use disorder [SUD], pain, physical symptoms, sleep, aggression, post-concussive symptoms)
Quality of life
Functional status
Patient satisfaction

# Methodology

## Methods Used to Collect/Select the Evidence

## Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Searches of Unpublished Data

# Description of Methods Used to Collect/Select the Evidence

Developing the Scope and Key Questions

The Clinical Practice Guideline (CPG) Champions, along with the Work Group, were tasked with identifying key questions (KQs) to guide the systematic review of the literature on posttraumatic stress disorder (PTSD). These questions, which were developed in consultation with the Lewin team, addressed clinical topics of the highest priority for the Department of Veterans Affairs (VA) and Department of Defense (DoD) populations. The KQs follow the population, intervention, comparison, outcome, timing and setting (PICOTS) framework for evidence questions, as established by the Agency for Healthcare Research and Quality (AHRQ). Table A-1 in the original guideline provides a brief overview of the PICOTS typology.

The Champions, Work Group, and evidence review team carried out several iterations of this process, each time narrowing the scope of the CPG and the literature review by prioritizing the topics of interest. Due to resource constraints, all developed KQs were not able to be included in the systematic evidence review. Thus, the Champions and Work Group determined which questions were of highest priority, and those were included in the review. Table A-2 in the original guideline contains the final set of KQs used to guide the systematic review for this CPG.

Conducting the Systematic Review

Extensive literature searches identified 1,667 citations potentially addressing the KQs of interest to this evidence review. Of those, 367 were excluded upon title review for clearly not meeting inclusion criteria (e.g., not pertinent to the topic, not published in English, published prior to study inclusion publication date, or not a full-length article). Overall, 1,300 abstracts were reviewed with 666 of those being excluded for the following reasons: not a systematic review or clinical study, did not address a KQ of interest to this review, did not enroll a population of interest, or published prior to January 2009. A total of 634 full-length articles were reviewed. Of those, 347 were excluded at a first pass review for the following: not addressing a KQ of interest, not enrolling the population of interest, not meeting inclusion criteria for clinical study or systematic review, not meeting inclusion criteria for any KQ, or being a duplicate. A total of 287 full-length articles were thought to address one or more KQs and were further reviewed. Of these, 150 were ultimately excluded. Reasons for their exclusion are presented in Figure A-1 in the original guideline document.

Criteria for Study Inclusion/Exclusion

*General Criteria*

Clinical studies or systematic reviews published on or after January 1, 2009 to March 2016. If multiple systematic reviews address a KQ, the Work Group selected the most recent and/or comprehensive review. Systematic reviews were supplemented with clinical studies published subsequent to the systematic review.
Studies must be published in English.
Publication must be a full clinical study or systematic review; abstracts alone were not included. Similarly, letters, editorials, and other publications that were not full-length clinical studies were not accepted as evidence.
Study must have enrolled at least 20 patients (10 per study group) unless otherwise noted (see Key Question Specific Criteria below).
Study must have reported on an outcome of interest.
Study must have enrolled a patient population in which at least 80% of patients were diagnosed with PTSD (or acute stress disorder [ASD] for KQ 10) and were age 18 years or older. If the percentage is less than 80%, then data must have been reported separately for this patient

subgroup.

*Key Question Specific Criteria*

For KQs 1–10 and 12, acceptable study designs included systematic reviews of randomized controlled trials (RCTs) and individual RCTs not evaluated in systematic reviews. If no relevant studies with these designs were found for a given KQ or sub-question, prospective nonrandomized comparative studies were evaluated for inclusion.
For KQ 11, acceptable study designs included systematic reviews, RCTs, or prospective cohort studies that statistically compared outcomes for patients with PTSD and a co-occurring medical or mental health condition to patients with PTSD and no additional medical or mental health condition. Large retrospective database studies (200 patients minimum) that performed multivariate statistical analyses of the effect of co-occurring conditions on patient outcomes were also acceptable.

Literature Search Strategy

*Bibliographic Databases Searched*

The Cochrane Database of Systematic Reviews (Cochrane Reviews) 2009 to February 2, 2016 (Wiley)
EMBASE (Excerpta Medica) 2009 to March 3, 2016 (Elsevier)
Health Technology Assessment Database (HTA) 2009 to February 2, 2016 (Wiley)
MEDLINE/PreMEDLINE 2009 to March 3, 2016 (Elsevier)
PILOTS: Published International Literature On Traumatic Stress 2009 to March 9, 2016 (ProQuest)
PsycINFO 2009 to March 3, 2016 (OVIDSP)
PubMed (In-process and Publisher records) 2009 to March 3, 2016 (National Library of Medicine [NLM])

*Gray Literature Resources*

The Evidence-based Synthesis Program (ESP) Reports 2009 to March 16, 2016 (VA)

Additional information on the search strategies, including topic-specific search terms and search strategies can be found in Appendix G in the original guideline document.

## Number of Source Documents

Overall, 122 studies (in 133 publications) addressed one or more of the key questions and were considered as evidence in this review. See Figure A-1 in the original guideline document for a study flow diagram.

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Quality of Evidence and Definitions*

| |
|---|
| High quality — Further research is very unlikely to change confidence in the estimate of effect. |
| Moderate quality — Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate. |
| Low quality — Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate. |
| Very low quality — Any estimate of effect is very uncertain. |

*Guyatt, G. H., Oxman, A. D., Vist, G. E., Kunz, R., Falck-Ytter, Y., Alonso-Coello, P., Schünemann, H. J. & the GRADE Working Group. (2008). GRADE; An emerging consensus on rating quality of evidence and strength of recommendations. *BMJ, 336*, 924-926.

# Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

# Description of the Methods Used to Analyze the Evidence

Abstracting and Managing Data

For each study included in this review, the following study level details were abstracted: country, purpose, and quality rating. For previous systematic reviews, the search strategy used, study selection criteria, and overall information about the evidence base, including number of included studies and overall patients enrolled were reported. For all studies, the reviewers abstracted data about characteristics of the included patients and interventions being assessed.

Assessing Individual Studies' Methodological Quality (i.e., Internal Validity or Risk of Bias)

As per the Department of Veterans Affairs/Department of Defense (VA/DoD) *Guidelines for Guidelines* document, Risk-of-bias (or study quality) of individual studies and previous systematic reviews was assessed using the U.S. Preventive Services Task Force (USPSTF) method. Each study was assigned a rating of Good, Fair, or Poor based on sets of criteria that vary depending on study design. Detailed lists of criteria and definitions of Good, Fair, or Poor ratings for different study designs appear in Appendix VII of the USPSTF procedure manual .

Data Synthesis

The evidence review team used a narrative approach to synthesizing the evidence for all the Key Questions. As indicated in the VA/DoD *Guidelines for Guidelines* document, the first line of evidence was previous systematic reviews. For questions in which a previous review was available, individual studies that met this review's inclusion criteria were used to supplement or update the previous review. The reviewers considered whether subsequent evidence supports the conclusions reported in the previous review. For questions for which no previous review was available, the evidence review team summarized the overall findings for the outcomes of interest of the studies that addressed a key question.

Assessing the Overall Quality of the Body of Evidence for an Outcome

The overall quality of the body of evidence supporting the findings for the outcomes of interest in this report was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. The GRADE system primarily involves consideration of the following factors: overall study quality (or overall risk of bias or study limitations), consistency of evidence, directness of evidence, and precision of evidence. Given time and resources, other factors such as publication bias may also be considered. For more information on the GRADE system go to the GRADE Working Group Web site .

The GRADE system rates the overall quality of the evidence as high, moderate, low, and very low (see the "Rating Scheme for the Strength of the Evidence" field). For instance, a body of evidence that consists of randomized controlled trials (RCTs) automatically starts with a rating of high quality. This rating can be downgraded if some of the RCTs have serious flaws such as lack of blinding of outcome assessors, not reporting concealment of allocation, or high dropout rate. Similarly, the quality can be downgraded or further downgraded if inconsistencies of findings are present or if there is a lack of precision surrounding an outcome's effect size.

Assessing Applicability

When describing the evidence base addressing a Key Question, the reviewers discussed aspects of the included studies, such as characteristics of included patients and treatments being assessed that may make the overall findings of the studies more or less applicable to the population, treatments, or outcomes of interest to this review.

## Methods Used to Formulate the Recommendations

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

Methods

The current document is an update to the 2010 *Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline (CPG) for the Management of Post-traumatic Stress* (PTSD CPG). The methodology used in developing the 2017 CPG follows the *Guideline for Guidelines*, an internal document of the VA and DoD Evidence-Based Practice Working Group (EBPWG) (see the "Availability of Companion Documents" field). This document provides information regarding the process of developing guidelines, including the identification and assembly of the Guideline Champions (Champions) and other subject matter experts from within the VA and DoD, known as the Work Group, and ultimately, the development and submission of a new or updated PTSD CPG.

The Champions and Work Group for this CPG were charged with developing evidence-based clinical practice recommendations and writing and publishing a guideline document to be used by providers within the VA/DoD healthcare systems. Specifically, the Champions and Work Group members for this guideline were responsible for identifying the key questions (KQs) of the most clinical relevance, importance, and interest for the management of patients with PTSD. The Champions and the Work Group also provided direction on inclusion and exclusion criteria for the evidence review and assessed the level and quality of the evidence. The amount of new scientific evidence that had accumulated since the previous version of the CPG was also taken into consideration in the identification of the KQs. In addition, the Champions assisted in:

- Identifying appropriate disciplines of individuals to be included as part of the Work Group
- Directing and coordinating the Work Group
- Participating throughout the guideline development and review processes

The VA Office of Quality, Safety and Value, in collaboration with the Office of Evidence Based Practice, U.S. Army Medical Command, the proponent for CPGs for the DoD, identified five clinical leaders as Champions for the 2017 PTSD CPG.

The Lewin Team, including The Lewin Group, Duty First Consulting, ECRI Institute, and Sigma Health Consulting, LLC, was contracted by the VA and DoD to support the development of this CPG and conduct the evidence review. The first conference call was held in November 2015, with participation from the contracting officer's representative (COR), leaders from the VA Office of Quality, Safety and Value and the DoD Office of Evidence Based Practice, and the Champions. During this call, participants discussed the scope of the guideline initiative, the roles and responsibilities of the Champions, the project timeline, and the approach for developing and prioritizing specific research questions on which to base a systematic review about the management of PTSD. The group also identified a list of clinical specialties and areas of expertise that are important and relevant to the management of PTSD, from which Work Group members were recruited. The specialties and clinical areas of interest included: ambulatory care, behavioral health, clinical pharmacy, clinical neuropsychology, family medicine, nursing, pharmacology, pharmacy, psychiatry, and psychology. The guideline development process for the 2017 CPG update consisted of the following steps:

- Formulating and prioritizing evidence KQs

- Convening a patient focus group
- Conducting the systematic review
- Convening a face-to-face meeting with the CPG Champions and Work Group members
- Drafting and submitting a final CPG on the management of PTSD to the VA/DoD EBPWG

Appendix A in the original guideline document provides a detailed description of each of these tasks.

Convening the Face-to-face Meeting

In consultation with the COR, the Champions, and the Work Group, the Lewin Team convened a three and a half day face-to-face meeting of the CPG Champions and Work Group members on August 29-September 1, 2016. These experts were gathered to develop and draft the clinical recommendations for an update to the 2010 PTSD CPG. Lewin presented findings from the evidence review of KQs 1-12 in order to facilitate and inform the process.

Under the direction of the Champions, the Work Group members were charged with interpreting the results of the evidence review, and asked to categorize and carry forward recommendations from the 2010 PTSD CPG, modifying the recommendations as necessary. The members also developed new clinical practice recommendations not presented in the 2010 PTSD CPG, based on the 2016 evidence review. The subject matter experts were divided into three smaller subgroups at this meeting.

As the Work Group members drafted clinical practice recommendations, they also assigned a grade for each recommendation based on a modified Grading of Recommendations Assessment, Development and Evaluation (GRADE) and U.S. Preventive Services Task Force (USPSTF) methodology. Each recommendation was graded by assessing the quality of the overall evidence base, the associated benefits and harms, the variation in values and preferences, and other implications of the recommendation.

In addition to developing recommendations during the face-to-face meeting, the Work Group members also revised the 2010 PTSD CPG algorithms to reflect the new and amended recommendations. They discussed the available evidence as well as changes in clinical practice since 2010, as necessary, to update the algorithms.

Grading Recommendations

This CPG uses the GRADE methodology to assess the quality of the evidence base and assign a grade for the strength for each recommendation. The GRADE system uses the following four domains to assess the strength of each recommendation:

- Balance of desirable and undesirable outcomes
- Confidence in the quality of the evidence
- Values and preferences
- Other implications, as appropriate, e.g.:
    - Resource Use
    - Equity
    - Acceptability
    - Feasibility
    - Subgroup considerations

The framework in Table A-4 in the original guideline document ("Evidence to Recommendations Framework") was used by the Work Group to guide discussions on each domain.

The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework, which combines the four domains. GRADE methodology does not allow for recommendations to be made based on expert opinion alone. While strong recommendations are usually based on high or moderate confidence in the estimates of effect (quality of the evidence) there may be instances where strong recommendations are warranted even when the quality of evidence is low. In these types of instances

where the balance of desirable and undesirable outcomes and values and preferences played large roles in determining the strength of a recommendation, this is explained in the discussion section for the recommendation.

The GRADE of a recommendation is based on the following elements:

Four decision domains used to determine the strength and direction
Relative strength (Strong or Weak)
Direction (For or Against)

Reconciling 2010 Clinical Practice Guideline Recommendations

Evidence-based CPGs should be current, which typically requires revisions of previous guidelines based on new evidence, or as scheduled, subject to time-based expirations. For example, the USPSTF has a process for refining or otherwise updating its recommendations pertaining to preventive services. Further, the inclusion criteria for the National Guideline Clearinghouse specify that a guideline must have been developed, reviewed, or revised within the past five years.

The PTSD Guideline Work Group focused largely on developing new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. In addition to those new and updated recommendations, the Guideline Work Group considered, with a limited review of the previous supporting evidence, the current applicability of other recommendations that were included in the previous 2010 PTSD CPG, subject to evolving practice in today's environment.

A set of recommendation categories was adapted from those used by the National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which older recommendations could have been updated. In brief, the categories took into account whether or not the evidence that related to a recommendation was systematically reviewed, the degree to which the recommendation was modified, and the degree to which a recommendation is relevant in the current patient care environment and inside the scope of the CPG. Additional information regarding these categories and their definitions can be found in Appendix A in the original guideline. The categories for the recommendations included in the 2017 version of the guideline can be found in the section on Recommendations (see the "Major Recommendations" field). The categories for the recommendations from the 2010 PTSD CPG are noted in Appendix E in the original guideline.

The CPG Work Group recognized the need to accommodate the transition in evidence rating systems from the 2010 PTSD CPG to the current CPG. In order to report the strength of all recommendations using a consistent format (i.e., the GRADE system) the CPG Work Group converted the USPSTF strengths of the recommendation accompanying the carryover recommendations from the 2010 guideline to the GRADE system. As such, the CPG Work Group considered the strength of the evidence cited for each recommendation in the 2010 PTSD CPG as well as harms and benefits, values and preferences, and other implications, where possible. The CPG Work Group referred to the available evidence as summarized in the body of the 2010 PTSD CPG and did not re-assess the evidence systematically. In some instances, peer-reviewed literature published since the 2010 PTSD CPG was considered along with the evidence base used for that CPG.

Where such newer literature was considered when converting the strength of the recommendation from the USPSTF to the GRADE system, it is referenced in the discussion that follows the corresponding recommendation, as well as in Appendix D in the original guideline.

The CPG Work Group recognizes that, while there are practical reasons for incorporating findings from a previous systematic review, previous recommendations, or recent peer-reviewed publications into an updated CPG, doing so does not involve an original, comprehensive systematic review and, therefore, may introduce bias.

Drafting and Submitting the Final Clinical Practice Guideline

Following the face-to-face meeting held August 29-September 1, 2016, the Champions and Work Group members were given writing assignments to craft discussion sections to support each of the new recommendations and/or to update discussion sections from the 2010 PTSD CPG to support the amended "carried forward" recommendations. The Work Group also considered tables, appendices, and other sections from the 2010 PTSD CPG for inclusion in the update. During this time, the Champions and Work Group also made additional revisions to the algorithms, as necessary.

## Rating Scheme for the Strength of the Recommendations

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.

Occasionally, instances may occur when the Work Group feels there is insufficient evidence to make a recommendation for or against a particular therapy or preventive measure. This can occur when there is an absence of studies on a particular topic that met evidence review inclusion criteria, studies included in the evidence review report conflicting results, or studies included in the evidence review report inconclusive results regarding the desirable and undesirable outcomes.

Using these elements, the grade of each recommendation is presented as part of a continuum:

Strong For (or "The Work Group recommends offering this option …")
Weak For (or "The Work Group suggests offering this option …")
Weak Against (or "The Work Group suggests not offering this option …")
Strong Against (or "The Work Group recommends against offering this option …")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

Recommendation Categories and Definitions

For use in the 2017 posttraumatic stress disorder (PTSD) Clinical Practice Guideline (CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated.

| Evidence Reviewed* | Recommendation Category* | Definition* |
|---|---|---|
| Reviewed | New-added | New recommendation following review of the evidence |
| | New-replaced | Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence |
| | Not changed | Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed |
| | Amended | Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made |
| | | |

| Evidence Reviewed* | Recommendation Category* | Definition* |
|---|---|---|
| | Deleted | Recommendation from the previous CPG that has been removed based on review of the evidence |
| Not reviewed | Not changed | Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed |
| | Amended | Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made |
| | Deleted | Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG |

*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

See Appendix A in the original guideline document for further details on categorization.

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

After developing the initial draft of the updated clinical practice guideline (CPG), an iterative review process was used to solicit feedback on and make revisions to the CPG. Once they were developed, the first two drafts of the Department of Veterans Affairs/Department of Defense (VA/DoD) CPG on posttraumatic stress disorder (PTSD) were posted on a wiki Web site for a period of 14 to 20 business days for internal review and comment by the Work Group. All feedback submitted during each review period was reviewed and discussed by the Work Group and appropriate revisions were made to the CPG.

Draft 3 of the CPG was made available for peer review and comment. This process is described in the Peer Review Process section in the original guideline document. Following the Draft 3 peer review and comment period, a second face-to-face meeting was convened on March 28-29, 2017, to discuss the feedback received and revise the CPG. After revisions were made based on the feedback received during the peer review and comment period, the Champions presented the CPG to the Evidence Based Practice Work Group (EBPWG) for their approval. Changes were made based on feedback from the EBPWG and the guideline was finalized.

The final PTSD CPG was submitted to the EBPWG in May 2017.

# Evidence Supporting the Recommendations

## Type of Evidence Supporting the Recommendations

Table A-2 in the original guideline document indicates the number and type of studies that addressed each of the questions. The evidence base consists primarily of systematic reviews and randomized controlled trials.

# Benefits/Harms of Implementing the Guideline Recommendations

## Potential Benefits

The expected outcome of successful implementation of this guideline is to:

Enhance assessment of the patient's condition and determine the best treatment method in collaboration with the patient and, when possible and desired, the patient's family and caregivers
Optimize the patient's health outcomes and improve quality of life
Minimize preventable complications and morbidity
Emphasize the use of patient-centered care

Refer to the "Discussion" sections following each recommendation in the original guideline document for information on the balance between benefits and harms for specific recommendations.

## Potential Harms

- In the Department of Veterans Affairs (VA) Evidence-based Synthesis Program review of posttraumatic stress disorder (PTSD) screening measures, the authors mention that inaccurately diagnosing PTSD in a patient who does not have PTSD could result in unintended harms to the patient from being labeled with a mental disorder and from side effects of treatment. There are also harms to the healthcare system from the inefficient use of resources.
- Nefazodone and phenelzine have potentially serious toxicities and should be managed carefully.
- The most frequent adverse effects of selective serotonin reuptake inhibitors (SSRIs) include sexual dysfunction, increased sweating, gastrointestinal upset, and drowsiness/fatigue. In 2004, the Food and Drug Administration (FDA) issued a box warning stating that, compared to placebo, antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults; however, there does not appear to be an increase in the risk of suicidality in adults beyond age 24 and there may be a reduced risk in adults aged 65 and older. Venlafaxine shares these potential harms and can increase blood pressure at higher dosages. Patients taking SSRIs and selective norepinephrine reuptake inhibitors (SNRIs) should have their dose tapered in order to reduce the chances of precipitating a discontinuation reaction, with the exception of fluoxetine (due to its long half-life). Patient preferences and comorbidities should be considered when deciding between these agents. Future research priorities should include further determination of the role and efficacy of antidepressants for the treatment of PTSD.

Refer to Appendix C, "Pharmacotherapy Dosing Table," in the original guideline document for a detailed list of adverse events and contraindications for specific drugs. Refer to the "Discussion" sections following each recommendation in the original guideline document for information on the balance between benefits and harms for specific recommendations.

# Contraindications

## Contraindications

A very low quality systematic review concluded that benzodiazepines are ineffective for posttraumatic stress disorder (PTSD) treatment, are associated with worse overall severity, worse psychotherapy outcomes, aggression, depression, and substance use, and are relatively contraindicated for patients with PTSD. Because benzodiazepine use is associated with tolerance and dependence, it can be very difficult to discontinue these medications due to significant withdrawal symptoms. Benzodiazepines are also

relatively contraindicated in patients with history of traumatic brain injury (TBI), sleep apnea, chronic obstructive pulmonary disorder (COPD), or who have high rates of comorbid alcohol misuse and substance use disorder (SUD), particularly Veterans with combat-related PTSD. Furthermore, pre-clinical evidence suggests that benzodiazepines may actually interfere with the extinction of fear conditioning and/or potentiate the acquisition of fear responses and worsen recovery from trauma.

Refer to Appendix C, "Pharmacotherapy Dosing Table," in the original guideline document for a detailed list of adverse events and contraindications for specific drugs.

# Qualifying Statements

## Qualifying Statements

- The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist in decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.
- This Clinical Practice Guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendations.
- Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations that are unique to an institution or type of practice. Every healthcare professional who is making use of these guidelines is responsible for evaluating the appropriateness of applying them in any particular clinical situation.
- These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

# Implementation of the Guideline

## Description of Implementation Strategy

This clinical practice guideline (CPG) and algorithms are designed to be adapted by individual healthcare providers with consideration of local needs and resources. The algorithms serve as a tool to prompt providers to consider key decision points in the course of an episode of care.

Although this CPG represents the recommended practice on the date of its publication, medical practice is evolving and this evolution requires continuous updating based on published information. New technology and more research will improve patient care in the future. The CPG can assist in identifying priority areas for research and to informing optimal allocation of resources. Future studies examining the results of CPG implementation may lead to the development of new evidence particularly relevant to clinical practice.

## Implementation Tools

Clinical Algorithm

Patient Resources

Pocket Guide/Reference Cards

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

# Institute of Medicine (IOM) National Healthcare Quality Report Categories

## IOM Care Need

Getting Better

Living with Illness

Staying Healthy

## IOM Domain

Effectiveness

Patient-centeredness

# Identifying Information and Availability

## Bibliographic Source(s)

Management of Posttraumatic Stress Disorder Work Group. VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Jun. 200 p. [259 references]

## Adaptation

Not applicable: The guideline was not adapted from another source.

## Date Released

2017 Jun

## Guideline Developer(s)

Department of Defense - Federal Government Agency [U.S.]

Department of Veterans Affairs - Federal Government Agency [U.S.]

Veterans Health Administration - Federal Government Agency [U.S.]

## Guideline Developer Comment

Not applicable

## Source(s) of Funding

United States Government

## Guideline Committee

The Management of Posttraumatic Stress Disorder Work Group

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## Financial Disclosures/Conflicts of Interest

At the start of this guideline development process and at other key points throughout, the project team was required to submit disclosure statements to reveal any areas of potential conflict of interest (COI) in the past 24 months. Verbal affirmations of no COI were used as necessary during meetings throughout the guideline development process. The project team was also subject to random web-based surveillance (e.g., ProPublica).

If a project team member reported a COI (actual or potential), then it was reported to the Office of Evidence Based Practice. It was also discussed with the posttraumatic stress disorder (PTSD) Clinical Practice Guideline (CPG) Work Group in tandem with their review of the evidence and development of recommendations. The Office of Evidence Based Practice and the PTSD CPG Work Group determined whether or not action, such as restricting participation and/or voting on sections related to the conflict or removal from the Work Group, was necessary. If it was deemed necessary, action to mitigate the COI

was taken by the Champions and Office of Evidence Based Practice, based on the level and extent of involvement.

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of Post-Traumatic Stress Working Group. VA/DoD clinical practice guideline for management of post-traumatic stress. Washington (DC): Veterans Health Administration, Department of Defense; 2010. 251 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Available from the Department of Veterans Affairs Web site .

## Availability of Companion Documents

The following are available:

- VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Clinician summary. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Jun. 34 p. Available from the Department of Veterans Affairs (VA) Web site .
- VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Pocket card. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Jun. 8 p. Available from the VA Web site .
- Guideline for guidelines. Washington (DC): Department of Veterans Affairs; 2013 Apr 10. 26 p. Available from the VA Web site .
- Putting clinical practice guidelines to work in VHA. Washington (DC): Department of Veterans Affairs. 64 p. Available from the VA Web site .

In addition, Appendix C of the original guideline document contains a pharmacotherapy dosing table.

## Patient Resources

The following is available:

- VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Patient education material. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Jun. 5 p. Available from the Department of Veterans Affairs (VA) Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI on August 31, 2004. The information was verified by the

guideline developer on November 15, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on April 30, 2007, following the FDA advisory on Sedative-hypnotic drug products. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on January 10, 2008, following the U.S. Food and Drug Administration advisory on Carbamazepine. This summary was updated by ECRI Institute on May 1, 2009 following the U.S. Food and Drug Administration advisory on antiepileptic drugs. This summary was updated by ECRI Institute on July 20, 2009 following the U.S. Food and Drug Administration advisory on Varenicline and Bupropion. This NGC summary was updated by ECRI Institute on April 8, 2011. The updated information was verified by the guideline developer on June 1, 2011. This summary was updated by ECRI Institute on January 23, 2013 following the U.S. Food and Drug Administration advisory on Zolpidem containing products. This summary was updated by ECRI Institute on May 22, 2014 following the U.S. Food and Drug Administration advisory on Eszopiclone (Lunesta). This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on July 18, 2017. The updated information was not verified by the guideline developer.

## Copyright Statement



# Disclaimer

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